VERMONT

www.labor.vermont.gov

DEPARTMENT OF LABOR
WORKERS COMPENSATION DIVISION
NATIONAL LIFE DRIVE, DRAWER 20
MONTPELIER, VT 05620-3401
(802) 828-2286

DOL Form 4 **Rev 5/05**

State File No.: _____

Insurance Co. File No.: _____

Date of Injury: _____

FEIN: _____

Social Sec. Number:

REPORT OF FATAL ACCIDENT

IMPORTANT: This report is to be used only when a work related injury results in a fatality. In all such cases, the Employer's First Report of Injury (Form 1) also must be filed.

1. Name of Employer: _____
2. Address of Employer: _____
3. Nature of Business: _____
4. Name of Injured Person: _____
5. Residence of Injured Person at Time of Death: _____
6. Date of Accident: _____
7. Date of Death: _____
8. Place where Injured Person Died: _____
9. ☐ Single ☐ Married ☐ Civil Union ☐ Widower ☐ Widow ☐ Divorced
10. Number of Children under Eighteen Years of Age: _____
11. If no Spouse or Reciprocal Beneficiary or Children Survive, State Other Relatives Dependent upon Deceased: _____
12. Relationship of Dependents: _____

Dated at _____ in the County of _____ this _____

day of _____, 20 _____ (year)

_____
Employer

By _____
Official Position

NOTE: Use ink or typewriter. Signatures must be in writing.